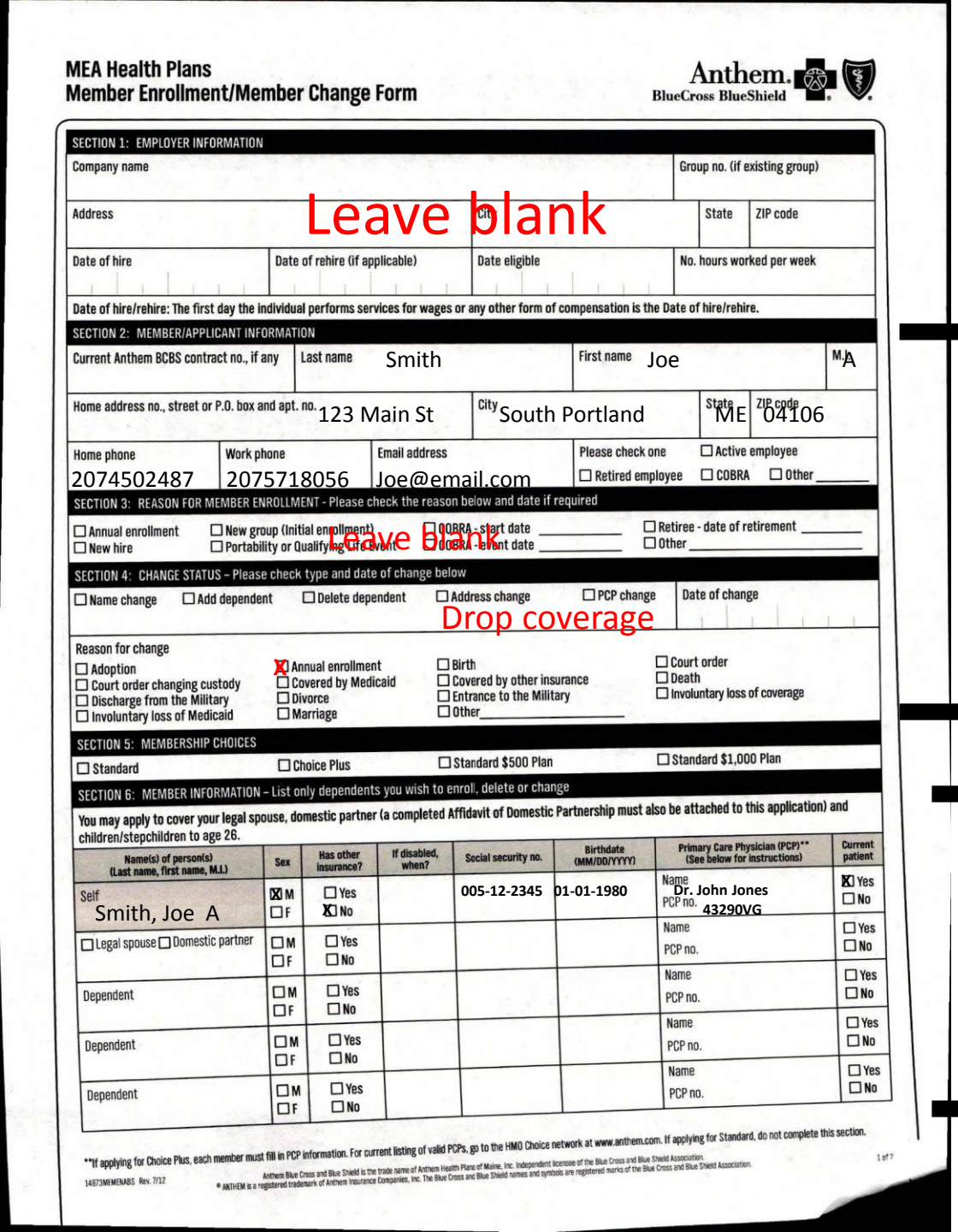

MEA Health Plans
Member Enrollment/Member Change Form

Anthem. BlueCross BlueShield

SECTION 1: EMPLOYER INFORMATION

Company name | Group no. (if existing group)

Address | City | State | ZIP code

Leave blank

Date of hire | Date of rehire (if applicable) | Date eligible | No. hours worked per week

Date of hire/rehire: The first day the individual performs services for wages or any other form of compensation is the Date of hire/rehire.

SECTION 2: MEMBER/APPLICANT INFORMATION

Current Anthem BCBS contract no., if any | Last name: Smith | First name: Joe | M.I.: A

Home address no., street or P.O. box and apt. no.: 123 Main St | City: South Portland | State: ME | ZIP code: 04106

Home phone: 2074502487 | Work phone: 2075718056 | Email address: Joe@email.com

Please check one ☐ Active employee ☐ Retired employee ☐ COBRA ☐ Other _____

SECTION 3: REASON FOR MEMBER ENROLLMENT - Please check the reason below and date if required

☐ Annual enrollment ☐ New hire ☐ New group (Initial enrollment) ☐ Portability or Qualifying Life Event ☐ COBRA - start date _____ ☐ COBRA - latest date _____ ☐ Retiree - date of retirement _____ ☐ Other _____

Leave blank

SECTION 4: CHANGE STATUS – Please check type and date of change below

☐ Name change ☐ Add dependent ☐ Delete dependent ☐ Address change ☐ PCP change | Date of change

Drop coverage

Reason for change

☐ Adoption ☐ Court order changing custody ☐ Discharge from the Military ☐ Involuntary loss of Medicaid
☒ Annual enrollment ☐ Covered by Medicaid ☐ Divorce ☐ Marriage
☐ Birth ☐ Covered by other insurance ☐ Entrance to the Military ☐ Other_____
☐ Court order ☐ Death ☐ Involuntary loss of coverage

SECTION 5: MEMBERSHIP CHOICES

☐ Standard ☐ Choice Plus ☐ Standard $500 Plan ☐ Standard $1,000 Plan

SECTION 6: MEMBER INFORMATION – List only dependents you wish to enroll, delete or change

You may apply to cover your legal spouse, domestic partner (a completed Affidavit of Domestic Partnership must also be attached to this application) and children/stepchildren to age 26.

Name(s) of person(s) (Last name, first name, M.I.)	Sex	Has other insurance?	If disabled, when?	Social security no.	Birthdate (MM/DD/YYYY)	Primary Care Physician (PCP)** (See below for instructions)	Current patient
Self: Smith, Joe A	☒ M ☐ F	☐ Yes ☒ No		005-12-2345	01-01-1980	Name: Dr. John Jones PCP no. 43290VG	☒ Yes ☐ No
☐ Legal spouse ☐ Domestic partner	☐ M ☐ F	☐ Yes ☐ No				Name PCP no.	☐ Yes ☐ No
Dependent	☐ M ☐ F	☐ Yes ☐ No				Name PCP no.	☐ Yes ☐ No
Dependent	☐ M ☐ F	☐ Yes ☐ No				Name PCP no.	☐ Yes ☐ No
Dependent	☐ M ☐ F	☐ Yes ☐ No				Name PCP no.	☐ Yes ☐ No

**If applying for Choice Plus, each member must fill in PCP information. For current listing of valid PCPs, go to the HMO Choice network at www.anthem.com. If applying for Standard, do not complete this section.

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I want to drop all coverage.

Fill in personal information in section 2; leave section 3 blank; mark ‘annual enrollment in section 4 and write in ‘drop coverage’.

Fill in info for yourself. Any dependents on the plan will automatically be dropped when you drop coverage.

SECTION 6: MEMBER INFORMATION – List only dependents you wish to enroll, delete or change. *CONTINUED*

Are you or any family members currently claiming Workers' Comp Medical Benefits? ☐ Yes ☐ No

If yes, name of claimant: _____

Leave blank

SECTION 7: PRIOR COVERAGE INFORMATION – This section must be completed

Have you or any other family member had health insurance coverage in the 90 days prior to your date of hire or the effective date of your new policy?

☐ Yes ☐ No **If yes, please complete the following:**

	Self	Legal spouse/ Domestic partner	Dependents 1	Dependents 2	Dependents 3
Name of insurance company					
Certificate (policy) no.					
Date coverage began					
Date coverage ended or is coverage still in effect?					

Leave blank

SECTION 8: MEDICARE BENEFICIARIES INFORMATION

Is anyone listed on this application currently eligible for Medicare?

☐ Yes ☐ No **If yes, please complete the following for each person to be covered who is eligible for or covered by Medicare.**

Name(s) of Medicare Beneficiaries	Health insurance claim no.	Medicare Part A effective date	Medicare Part B effective date	Medicare Part D effective date	Check all reasons you qualified for Medicare
					☐ Age 65 ☐ Disability ☐ ESRD
					☐ Age 65 ☐ Disability ☐ ESRD
					☐ Age 65 ☐ Disability ☐ ESRD
					☐ Age 65 ☐ Disability ☐ ESRD

Leave blank

SECTION 9: APPLICANTS – Only complete this section if you are requesting coverage

I am requesting coverage for myself and all dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Agreement and Certificate of Coverage. I understand that each family member's care must be provided or arranged by his/her Primary Care Physician (PCP) (does not apply to Standard) except as described in my Certificate of Coverage.

Applicant signature	Print name	Date
X		

Sign, print, date.

SECTION 10: NO COVERAGE – Complete this section if you do not want coverage

I do not wish to enroll in a plan. Please check one: ☐ I have other coverage **OR** ☐ I do not have any other coverage

I understand that the opportunity to enroll at any future date will be subject to the regulations of Anthem Blue Cross and Blue Shield.

Applicant signature	Print name	Date
X		

DO NOT sign here.

For questions about MEA Choice Plus or MEA Standard,
please call 1-800-527-7706, or in the Portland area, 1-207-822-8282.
All questions need to be completed before this application can be processed.